Ph# 619 1421

FAX

Note: All faxes cost $0.25 per page. An additional $0.25 cost will be added if a cover page is need.

Your Name: PASTOR T. HARRIS Brown FATHER DEAD SON - THEARO
Theodis Theard

Would you like to send a cover page? (Note: a cover page costs $0.25)

Yes________ No________

If yes, complete the following for the fax cover page.

To: DEAKIN

Subject: 537.050 [illegible]

Notes: LAWSUIT IN PENDING
WRONG DEATH CASE
STEMMING 9-10-21 CAR HIT RUN

Scanning: Front Side _____ Both Sides _____

Fax Number: (877) 786 55 71

Would you like an email confirmation? Yes _____ No _____

Email confirmation is the only way to know if the fax was sent successfully. If yes, please provide the following:

Email Address: Force 1949 @ Hotmail.com

Any additional email addresses: ________________________________

District
PO BOX 771728
SAINT LOUIS MO 63177-1728

30 DAYS PAST DUE

FEDERAL TAX ID: 43-0721769

WE DO NOT HAVE YOUR INSURANCE ON FILE

Balance listed is past due

You may provide your insurance using any of the contact options listed in the "Need to provide insurance or make a payment?" section. If you do not have insurance, you are responsible for the amount due.

Tell us what you thought about your EMS experience at www.emsbilling.com/patient

Account Details

Statement Date:	11/23/2021
Date of Service:	09/10/2021
Run Number:	**21-1615899**
Bill To:	THEOND BROWN
Patient Name:	THEOND BROWN
Origin:	13201-13299 NEW HALLS FERRY RD SB FLORISSANT MO 63033
Destination:	SSM DEPAUL HEALTH CENTER

NEED TO PROVIDE INSURANCE OR MAKE A PAYMENT?

ONLINE: www.emsbilling.com/patient

BY MAIL: Complete the reverse side of this statement and return or send check/money order and include the lower portion. An enclosed envelope has been provided for your convenience.

BY PHONE: Call 1(800) 814-5339 Monday through Friday 8 am to 6 pm EST.

Para asistencia en español, por favor llame a sevicio al cliente al 1(800) 814-5339.

Account Activity

Description	Quantity	Total
ALS Emergency Transport	1	$1,050.00
Mileage	11.3	$135.60
Total Charges:		**$1,185.60**
Amount Due Before Insurance:		**$1,185.60**

PLEASE DETACH AND RETURN THE BOTTOM PORTION WITH YOUR PAYMENT. A4

PATIENT / GUARANTOR NAME: THEOND BROWN

STATEMENT DATE:	11/23/2021
DATE OF SERVICE:	09/10/2021
RUN NUMBER:	21-1615899
AMOUNT DUE:	$1,185.60
AMOUNT ENCLOSED:	$

We accept the following for payment (see reverse side):

VISA MasterCard DISCOVER

PLEASE MAKE CHECK OR MONEY ORDER PAYBLE TO:

Florissant Valley Fire Protection District
PO BOX 771728
SAINT LOUIS MO 63177-1728

Florissant Valley Fire Protection District
PO BOX 771728
SAINT LOUIS MO 63177-1728

ELECTRONIC SERVICE REQUESTED

9024005791 PRESORT PBPS013 <B>

THEOND BROWN
9901 LILAC DR
SAINT LOUIS MO 63137-3350

Federal Tax ID: 43-0721769
Incident Number: 21-4009352

In order to file health insurance on your behalf, your signature is REQUIRED.

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to the EMS provider for any services provided to me now, in the past, or in the future. I understand that I am financially responsible for the services provided to me regardless of my insurance coverage and in some cases, may be for an amount in addition to that which was paid by my insurance. I agree to immediately remit any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to the EMS provider. I authorize the EMS provider to appeal payment denials or other adverse decisions on my behalf without further authorizations. I authorize and direct any holder of medical information or documentation about me to release such information to the EMS provider, and its billing agents, and/or the Centers for Medicare & Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me now or in the future. A copy of this form is as valid as an original.

Please visit us online at www.emsbilling.com/patient to sign electronically.

Patient signature: _____ Date: _____

Patient Representative: If the patient is unable to sign, please complete the section below. **If the reason the patient is unable to sign is not listed below, the patient will remain responsible for the full balance.** Please note, the Patient Representative is not financially liable for services rendered to the patient.

Unable to sign because (REQUIRED): _____

I am signing on behalf of the patient to authorize submission of the claim. By signing below, I acknowledge that I am one of the authorized signers listed below.

Patient Legal Guardian Person receiving governmental benefits on behalf of patient

Person who arranges for patient's treatment or exercises other responsibilities for their affairs

Representative of a medical facility that provides other care, services or assistance to the patient

Representative Name _____ Representative Signature _____

Contact Phone # _____ Date _____

INSURANCE INFORMATION

TYPE: MEDICARE MEDICAID INSURANCE

NAME _____

NAME OF INSURED/GUARANTOR

POLICY HOLDER _____

POLICY HOLDER'S SOCIAL SECURITY # _____

INSURANCE POLICY # _____

GROUP # _____

ANY ADDITIONAL INSURANCE

TYPE: MEDICARE MEDICAID INSURANCE

NAME _____

NAME OF INSURED/GUARANTOR

POLICY HOLDER _____

POLICY HOLDER'S SOCIAL SECURITY # _____

INSURANCE POLICY # _____

GROUP # _____

THIRD PARTY LIABILITY INSURANCE

IF ACCIDENT RELATED, WHAT TYPE OF INSURANCE ARE YOU PROVIDING ?

WORKERS COMPENSATION AUTO OTHER INSURANCE

NAME OF INSURED/ POLICY HOLDER _____

CASE/CLAIM NUMBER # _____

EMPLOYER'S NAME AND ADDRESS _____

CLAIM MAILING ADDRESS _____

POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S EMPLOYER (IF APPLICABLE) _____

EMPLOYER'S TELEPHONE # _____

INSURANCE CO. TELEPHONE # _____

Need to make a payment?

Credit card or check (ACH) payments can be made at www.emsbilling.com/patient or by calling 1 (800) 814-5339. Payments made via our website will provide a confirmation number and option to receive the confirmation by email. Credit card payments returned by mail will not be processed.

There is a flat $5.00 convenience fee applied to each credit card transaction. To avoid this fee, please pay by check (online/mailed) or money order.

TRAVELERS

THE STANDARD FIRE INSURANCE COMPANY
Po Box 650293
Dallas, TX 75265-0293

12/01/2021

Theodis Brown
9901 Lilac Drive
Saint Louis MO 63137

Insured:	Connie Frazier
Claim Number:	ISH0054
Claimant:	Theond Brown
Date of Loss:	09/10/2021

Dear Mr. Theodis Brown,

Please allow this letter as a follow-up to our call regarding your son's injury claim. Again, I wish to extend my condolences for your loss.

In our call you indicated that both you and your wife wish to pursue a wrongful death claim against our insured driver because you believe our driver, Kenya Frazier was the responible party for his death.

I explained to you that I will need to investigate the cause of your son's death in order to evaluate the claim. In order to do that, I will need to obtain all of his medical records and bills, including but not limited to his initial hospital stay at Depaul Hospital, ambulance records, follow-up treatment records, and the records from Christian Northeast Hospital.

Under a separate cover I am sending to you an authorization and provider form. These forms will need to be completed and returned to me. You will need to provide documents that show/support that you are authorized to complete these forms on behalf of your son.

Once I have been able to obtain his medical records and bills, I will be in a position to respond.

Sincerely,

Geoffrey Perkins
Claim Professional
Direct: (913)402-5409
Office: (800)348-6944 Ext. 9134025409
Fax: (877)786-5571
Email: GPERKINS@travelers.com

TRAVELERS

THE STANDARD FIRE INSURANCE COMPANY
Po Box 650293
Dallas, TX 75265-0293

12/01/2021

Theodis Brown
9901 Lilac Drive
Saint Louis MO 63137

Insured:	Connie Frazier
Claim Number:	ISH0054
Claimant:	Theond Brown
Date of Loss:	09/10/2021

Dear Mr. Theodis Brown,

Thank you for taking time to speak with me. As we discussed, I am writing to request that you complete the enclosed medical authorization form. This will allow me to obtain your medical records related to this incident so that I may better understand your claim.

As part of our review, one of the tools that we may use in evaluating this claim is a medical billing review application. This application checks treatment billing for duplicates or unrelated charges and verifies treatment codes. The software also uses data to provide comprehensive and up-to-date treatment and pricing information for medical services. This allows us to review and verify medical treatment and bills. We use this information to help assess the reasonableness and reasonable cost of the medical treatment you have received.

The medical billing review application uses a database provided by FAIR Health, Inc. FAIR Health, Inc. is an independent, not-for-profit organization that was created to serve as an independent, objective, and transparent source of healthcare reimbursement data for consumers, insurers, healthcare providers, and others. Their database consists of millions of provider charge records that FAIR Health, Inc. continuously updates. The medical billing review application does not make any recommendations regarding the severity of your injury; it is used to assure proper accounting of medical bills and is also one factor used to determine the reasonableness of those bills. If you would like any additional information about the database that the medical billing review application uses, please feel free to visit the FAIR Health, Inc. website: www.fairhealth.org.

After I have reviewed and evaluated your claim, I will contact you. In the meantime, if you have any questions or concerns, please contact me at (913)402-5409 or GPERKINS@travelers.com and I will be glad to discuss them with you.

Sincerely,

Geoffrey Perkins
Claim Professional
Direct: (913)402-5409
Office: (800)348-6944 Ext. 9134025409
Fax: (877)786-5571
Email: GPERKINS@travelers.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS-CLAIM

Patients Name & Address:
Theond Brown
9901 Lilac Drive, Saint Louis, MO 63137

Date of Birth: [redacted]1975

Telephone Number:

Claim/File Number: 077-AB-ISH0054-R

I authorize the use or disclosure of my (or my minor child/ward) protected health information as described below.

Organization authorized to release the information: **See Provider List**

Release information to: The Standard Fire Insurance Company

I authorize release of my entire medical records and bills which are relevant and/or related to the injuries sustained on the above date of loss 09/10/2021 to present.

I understand that information in my health record may include information relating to HIV/AIDS Confidential Information and may include psychosocial, mental health or alcohol and drug use information and I **do not** authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Director of Medical Records. This would not apply to information that has already been released prior to my written revocation. Unless otherwise revoked, this authorization will expire on the following date: **Settlement or other conclusion of the above-referenced claim and/or litigation.**

I understand that signing this authorization is voluntary. My treatment, payment by a health insurance company, enrollment in a health plan, or eligibility for benefits from a health insurance company will not be conditioned upon my authorization of this disclosure.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I hereby authorize acceptance of a copy of this instead of an original.

I understand that by signing this authorization, I have the right to receive a copy of it.

_____ _____

Signature of Patient or Legal Representative **Date**

Printed name of patient/Legal Representative: _____

If signed by Legal Representative, describe relationship to patient and authority to act:

_____

Please provide the following information via:

Mail to: The Standard Fire Insurance Company, Geoffrey Perkins, Po Box 650293, Dallas, TX 75265-0293
Via fax: (877)786-5571
Via email: GPERKINS@travelers.com

MEDICAL TREATMENT PROVIDER LIST

Claim/File #: 077 AB ISH0054 R

Name of Person Requesting the Medical Records: Geoffrey Perkins

Claim Professional for the following Underwriting Company:
The Standard Fire Insurance Company

Patient Name: Theond Brown

Address: 9901 Lilac Drive
Saint Louis, MO 63137

Signature: _____

Please list all medical providers who have treated you and medical facilities where you have been treated in the last years.

(Name)	(Name)
(Address)	(Address)
(City, State, and Zip)	(City, State, and Zip)
(Phone Number)	(Phone Number)
(Name)	(Name)
(Address)	(Address)
(City, State, and Zip)	(City, State, and Zip)
(Phone Number)	(Phone Number)
(Name)	(Name)
(Address)	(Address)
(City, State, and Zip)	(City, State, and Zip)
(Phone Number)	(Phone Number)

Please attach additional pages, if necessary.

notice of impending wrongful death lawsuit under section 537.090rsmo2021 to wit;

theodis brown <force1949@hotmail.com>

Sat 2/26/2022 11:00 AM

To: chief theodis brown <mplefireprotectioncompany@gmail.com>

notice is heberby given 537.090rsmo; the aggreived elderly married couple parents of their deceased biological son mister theond brown disabled hanicap mental ill outpatient accident crippled son of mister pastor theodis brown sr his biological father&his wife and biological mother of our son mrs gail brown as his caregivers in lifetime before sudden death where foulplay suspected due to facts& circumstance surrounding his sudden death in the er of cne on the am of 11/20/21 on life support until the staff of cne decided to take him off without parents consent or knowlege on his whereabouts before finding out theond brown was admitted as unknown person ?/ yet his id card house key missing his property gave undertaker by cne in property list of blue shoes only? as his only property from 9935 diamond drive site he was removed from by the caller of 911 call witness who claimed he didnt know theond address but gave his name to cne& rfpd unit staff who witheld id from cne staff erc >???who treated him as unknown person???etc admitted him as cne er patient to the icu put on life support unit since he wasnt a doa case???plus 911 caller knew his id told emt his name but didnt his address??? as such this wrongful death lawsuit to be invoked under frcp,to let his parent recover economic and noneconimic damages under due process of the law to seek justice in their beloved sons sudden death which caused a family hardship on parents loss of relationship? lost of service and support? lost of deceased sons income??ssi check?? which dont pay out of the pocket added financial burden on elderly parents caregivers in life and money hardship in death to cover the several thoundsand cost for clark son furneral home cost to undertaker??plus mediacl cost undertaker cost that poor parent as ifp plaintiff pro se litigant cant afford??from time of his hit run car crash??crippling life threa crash injuries crippled wheelcair plus walker user ?from time of crash sept 2021 to his sudden death 11/20/21?? with his undertaker bill cost on dec 1st 2021???his dec 5th wake and creamation due family parent not able to afford regular furneral ???to poverty as poor peoples on verge of bankrucpcy?losing home everything they own to being homeless as elderly marreied couple since 1968 as only marriage of the mr and mrs brown parent of son now deceased due to wrongdoers??